OSBORNE

STOP Think!

MAKE BETTER DECISIONS

September 2021

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Introduction

September 2021 - STOP Think!

Hello and welcome to our September STOP Think! Cascade Briefing. Well, what an exciting month we had in August!

Hopefully, you will have all seen our recent communications advising that as of the 10th September, Osborne Infrastructure Limited will be under the new ownership of Sullivan Street Partners (SSP).

This is a very exciting opportunity for our people, with great benefits for our customers and suppliers too. As a fully independent entity, we will be able to prioritise all our business decisions around the specific needs of the Infrastructure Transport customers, uniting behind a common purpose and business strategy. The business is in strong shape so there will be no radical change in what we do, who we do it for or how we do it! However, we will build on the solid foundations that we have and work with our SSP colleagues to deliver the ambitious growth and performance improvements that we have previously set out within our Business Plan.

Introduction to Sullivan Street Partners

Sullivan Street Partners are specialists in acquiring and growing businesses to reach their full potential. They have an impressive track record in extracting business divisions from wider groups and helping them to achieve operational excellence. Yet, what is most impressive, is their approach to responsible ownership, their focus on their people and customers, and alignment with our traditional Osborne values. The founding Partners, Layton Tamberlin and Richard Sanders, have known each other for over 25 years and have acquired much transferrable expertise from working in other industries and with other businesses. They share our enthusiasm and energy for constant learning and improvement and extend this to all the companies they work with. I am extremely confident that they will be great custodians of our business.

Strengthened Leadership Team

I will continue to lead our new business; proud to have been asked to fulfil a wider role as the CEO of Osborne Infrastructure Ltd. Critically, I will continue to enjoy the full support from my Infrastructure Board colleagues, Operations Director Matt Smith, Pre-Delivery Director Mike Purdue and Commercial Director Gavin Pritchard, and our wider management teams. I am also pleased that we will be strengthening our leadership team with the appointment of David Fison, previously CEO of the Osborne Group, as our new Chairman and Tony Bickerstaff as our new CFO. Tony joins us with a wealth of experience from having undertaken key finance leadership roles with both Costain and Taylor Woodrow.

An Exciting Journey Ahead

Clearly, there is an element of nostalgia for us all. I feel this as much as anyone, with this month marking my 25th anniversary working for the Osborne Group. However, the heritage, values and culture of Osborne are so firmly embedded within our Infrastructure Business that I have no concerns that we will continue to be an organisation that is chosen by our customers and suppliers as well as being a great place for our people to work.

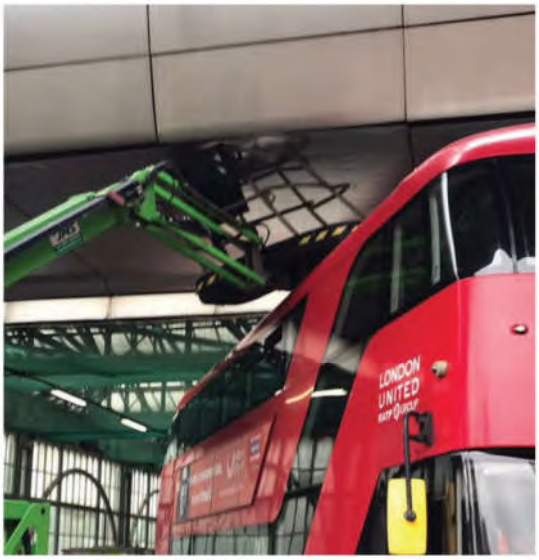
I also passionately feel that now is the perfect time for us to spread our wings and take full advantage of our reputation, our growing team and the thriving Infrastructure sector. With a sole focus on one market, and dedicated support functions working with a common purpose, there really is no limit to what we can achieve together with our customers and suppliers.

With our collaboration with SSP and the support and investment that this will bring, we now have control of our own destiny. I feel that our collective strengths will allow us to evolve our business into the market leader that we strive to be, delivering the best civil engineering and infrastructure services across the whole of the UK.

Stay safe and well over the coming month.

John Dowsett
Managing Director Infrastructure

MEWP Incident (18th August 2021)



Crushed MEWP Basket

Correctly stored MEWP - Image courtesy of IPAF

What Happened?
A double decker bus struck the elevated basket of a stored mobile elevated working platform (MEWP) wedging it between the roof of the bus and the underside of the over-bridge connecting Waterloo station to Waterloo East station. No one was hurt but clearly this had the potential to have had a serious outcome.

The MEWP was being stored in a designated storage area outside station reception on Cab Road with the basket in the raised position. Leaving MEWPs in this way would appear to have become custom and practice, but this is not in line current British Standards and IPAF guidance on the correct storage and security of MEWP's when not in use.

The incident is still under investigation.

Impacts

1. Damaged roof to bus.
2. Damaged cladding to overbridge which needed to be examined and inspected by an engineer.
3. Crushed and bent basket to MEWP.

Immediate Action
If you are using and storing MEWPs on site, then you must ensure that:

1. They are only used and operated by competent persons, such as those holding an IPAF card correctly endorsed for the equipment in use.
2. The competent person correctly stores the MEWP in the lowered position when they are no longer in use as detailed on training courses.
3. Any additional security devices to immobilise the MEWP are used e.g., battery isolator lock off.
4. The storage area is secured e.g., in a compound with locked gates.
5. There are suitable key custody procedures and that keys are only issued to authorised users.

Contact a SHE Advisor if you have any queries.

MEWP incident
Last Updated: 18/08/2021

Service Strike Lessons Learned (No. 151 - 7th August 2021)

Damaged ducting.

Image showing position of duct in relation to marked location as per as built information.

What Happened?

A 20t excavator being operated by an Osborne supply chain partner struck a Western Power Distribution (WPD) telecoms duct. The duct was installed 250mm below ground level. The machine was scraping sub-base to prepare an area for the machine to sit on to install drainage.

The operation being conducted by mechanical means was within 1m (Highways England Raising the Bar requirement) of the service markings.

Impacts

This strike resulted in no injuries, but damage was caused to the 100mm telecoms duct and 2 out of 3 sub ducts were damaged. Following WPDt visit it was confirmed that the cable was damaged at the strike location. This damage to the cable could not be visibly seen at the strike location but was identified through fault finding.

Work was stopped until investigation was completed. WPD undertook a repair of the service.

Lessons Learned:

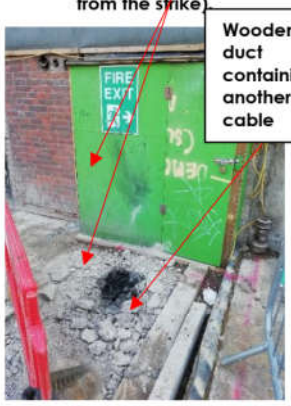
1. Ensure all services are exposed (Trial Holes) wtihn your dig areas, especially if not detectable using CAT scanning, even if previously installed and asbuilt records held.
2. Ensure ALL involved in breaking ground operations are adequately briefed and fully understand service locations, permit constraints and the safe digging practices required.
3. Consider exposing services in close proximity to but not within permitted digging areas to give a physical confirmation of their location.
4. Ensure service safety margins are marked on site in accordance with OIL "*Permit to Break Ground Guidance - SGN-BSV-002" which states:*
   "the line of location for every service has been clearly marked and safe hand dig margins also clearly indicated ON THE GROUND, in appropriately coloured paint".
5. Although not currently an OIL procedural requirement, both longitudinal and lateral permit extents should be marked on site to establish permitted working area.

STOP Think! Have a conversation. Make the safe choice

Alert No: 151
Last Updated: 07/08/2021

NON-INFRASTRUCTURE – Cable Strike (No. 152 – 17th August 2021)

Picture 1 – location that was being broken out by the excavator (Note burn marks from the strike).



Picture 2 – Cable that was struck.

Picture 3 – Visible indication of the struck cable when the temporary door is open

This STOP Think! Moment is to share learning following a recent incident where an electrical cable was struck by an excavator on an Osborne Construction Site.

What happened?

An underpinning contractor was carrying out excavation works in an area that is concreted.

They reportedly checked the area with a CAT and Genny (the CAT was checked during the investigation and suspected to be faulty) and visually identified a cable in a shallow wooden duct in the concrete on the right-hand side in front of the temporary wooden door. The door was protecting electrical services on the wall that had been exposed following recent demolition works and is locked and under Osborne control.

A permit to break ground was in place, which included a drawing that only showed one cable in this area. This drawing was out of date and a recent SUMO survey, (utility survey), had been carried out which identified two cables in this area. The SUMO survey was not attached to the permit.

The operatives, who were not aware of what was behind the door, started breaking out the concrete using a pneumatic hand breaker but found this ineffective so decided to use a breaker instead.

The excavator started to break out the concrete and hit a cable which is located at a depth of approximately 225mm.

Impacts

- ✓ Residents in the area were left without power until the cable was repaired.
- ✓ There were no injuries because of this incident, however, this could very easily have been very different.

Immediate actions.

- ✓ Excavation work was stopped, and the Osborne site team were made aware of the incident.

Lessons

- ✓ This incident highlights the importance of ensuring excavation works are carried out in strict compliance with the arrangements of the permit to break ground. (Osborne Cat and Genny checks were not carried out to verify contractors checks).
- ✓ All ground-breaking activities must be carried out in strict accordance with HSG47 (Avoiding danger from underground services) and Osborne procedures.
- ✓ The incident is under investigation.

Alert no: 152
Issued: 17 August 2021
Updated: N/A

Don't forget to book your **NSCD Refresher**

As seen in "Home Safe" Network Rail are holding free negative short-circuiting device (NSCD) refresher sessions on;

- **Thursday 23 September from 09:00 – 19:00**
- **Tuesday 29 September from 02.00 to 07.00.**

The events are being held at Basingstoke Campus, Gresley Road, Basingstoke, RG21 4FS and are available to all operatives, whether they currently hold the NSCD operator competency or not.

The aim of the sessions is to ensure that all operatives are familiar and refreshed with the rules around B4 isolations and the operation of NSCDs.

They will take less than 30 minutes and will be followed by a Q&A session with the Network Rail NSCD leads.

How to sign up

If you or your team would like to attend, please contact David Pereira (david.pereira@networkrail.co.uk) with an estimate of the number of places you require, so these can be secured for you.

NSCDs provide an easier and safer way to deliver electrical isolations. Please do take a look at this short film which explains more about how NSCDs are not only providing a step change in track worker safety, but also to people's confidence and productivity;

Negative Short Circuit Devices Explained

Reminder: Hands-Free BANNED whilst Driving

Please can we remind you that in accordance with our Life Saving Rules, the use of all hand-held phones, hands-free phones or other mobile devices is **BANNED** for ALL in Infrastructure while driving.

Please do not even answer the phone if you are driving.

The fine for using a mobile / PDA whilst driving is 6 points and £200.

Your mobile can only be used if you are parked up safely with the engine off and the keys out of the ignition.

If you want to use the sat nav on a mobile or plug the charger in, you must set it up before the keys are in the ignition and don't touch it once the engine is on.

- Do not touch your phone if you stop at lights.
- Do not touch your phone if you are parked up with the engine on.
- Do not scroll for tracks on your mobile while driving - have your playlist set up before entering the car.
- Do not move your phone while the engine is on.

If you call someone and they are driving, **hang up.**

If you are a passenger and the driver is using a phone, **take it off them!**

Keep your phone out of sight and avoid all temptation – **put it in your glove box!**

YOUR Life Saving Rules

An Insight to **Temporary Works**

Please do take a look at The Temporary Works Forum website. They have launched a short video "What is Temporary Works?" which gives a great insight into the importance of temporary works. Well worth a watch;

https://www.twforum.org.uk/home

Thumbs Up to Enter

Failing to follow the rules around exclusion zones account for almost half of people and plant incidents with potential for injury in the Network Rail Southern Capital Delivery region.

To help remind people of the simple rule "wait for the thumbs up signal before entering an exclusion zone," Southern Shield have made a great new poster.

To download a copy, please visit the Southern Shield website or click below;

Thumbs Up Poster

Lean Six Sigma

We have two exciting opportunities to further develop your Lean Six Sigma knowledge.

Join Kimberley Wild for a virtual classroom Lean Champion Training Day that is the equivalent to Lean Green Belt Training. The Lean Champion training is interactive and requires participation in exercises. Or why not complete Your Lean Six Sigma Green Belt at your own pace via an online provider. This training is delivered through approximately 6.5 hours of videos and a quiz upon completion.

Lean Champion Training

Lean Six Sigma - Green Belt

Both courses deliver the same content, just in a different style. If you complete either of these courses, you will be invited to attend a monthly Lean Forum to support you in using

Lean tools and to share benefits and efficiencies gain.

For further information please contact Kimberley Wild.

Kimberley is always looking for ways to improve our content on the Lean Launch Pad. Please do let her know what you would like to see on the page by leaving feedback, submitting an IO with your ideas, or sending an email. Thank you.

How to **Recycle your Soft Plastics**

Did you know that you can now recycle soft plastics like crisp packets and bread bags at certain Co-op stores.

Soft plastics are lightweight plastics that often cannot be placed in recycling bins at home.

To find out which Co-op stores near you currently have a recycling unit please visit their website;

Soft Plastic Recycling at your Coop Store

Commercial Vehicle **Incident Prevention**

National Highways Free Van Driver Resources

National Highways, along with Driving for Better Business have developed a new "Van Driver Toolkit" with the aim of making our roads safer. All the resources within the Toolkit are totally free are designed to help clear up some of the misunderstandings around the safe and compliant operation of vans. They can be accessed through registering your interest at;

vandrivertoolkit.co.uk

Registration is simply to keep you updated as new resources get added to the Toolkit. All resources are written with the driver in mind in a clear and direct style. These will soon be enhanced with some ready-made toolbox talks and later in the year they will be launching a new e-learning package. So please do watch this space!

And just to get you thinking… do you really know how little visibility that a lorry driver has? Please share this video with your colleagues;

Lorry Blindspot

Highways Safety Hub

The July edition of the Highways Safety Hub Newsletter is now available as linked below;

Highways Safety Hub - July '21 Newsletter

The Newsletter includes useful links, alerts and news updates and this month has a very interesting article on laptop safety and battery health. Well worth a read!

Please visit the library of briefings on the Highways Safety Hub which also includes much useful information for working on the road network along with all the National Highways Safety Alerts;

Highways Safety Hub

Passport

As Passport continues to embed across the National Highways Network, there is a large amount of information to share with you on the scheme.

The August edition of "Inside Lane" is now available and in this issue focusses on the Highways Common Induction and the different advantages it offers across the entire supply chain.

Inside Lane - August Edition

Rail Wellbeing Live
Registration Now Open

Even better than last year, Rail Wellbeing Live is a two-day virtual event where you can 'pick and mix' what you want to do and dip in and out when you like.

Speakers include Jason Fox from SAS: Who Dares Wins; Rebecca Adlington, Double Gold Olympic Swimmer; Bryony Gordon, author of the book *Mad Girl*; and Dr Rupy Aujla, the NHS GP behind *The Doctor's Kitchen* project. Plus, of course leaders from across the industry. Simply visit the Rail Wellbeing website to register for free;

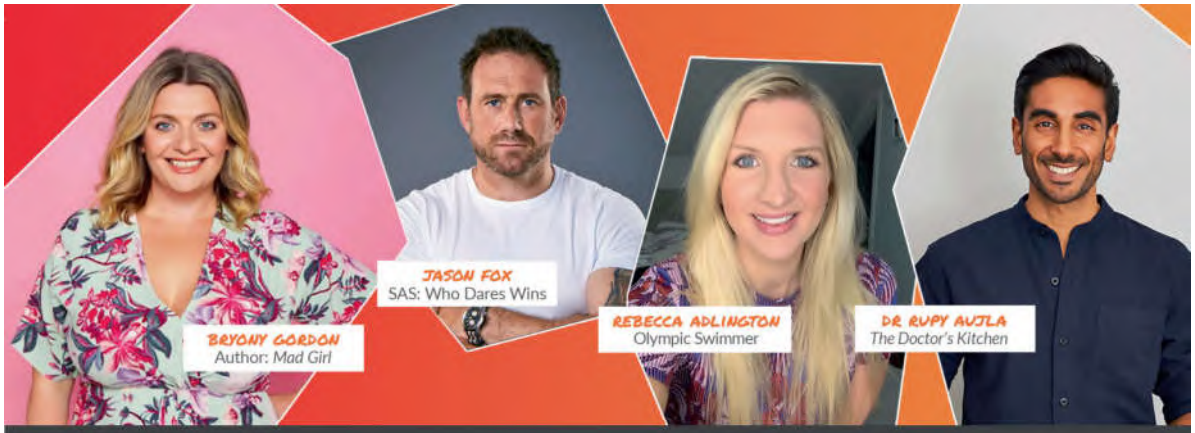
Rail Wellbeing Live 2021 Registration

This is the chance for the whole industry to get together online to focus on our health and wellbeing to create a happier, healthier future for everyone.

In the meantime, don't forget to join the Wednesday Wellbeing Sessions that are hosted on the first Wednesday of every month. September's topic was all about work-life balance and can be viewed on catch-up.

An unhealthy work-life balance not only impacts your mental wellbeing but also your physical health, hence it is really important to understand what we can do to keep work and life separate.

Whilst Rail Wellbeing is being delivered in partnership with Network Rail, the content applies to **EVERYONE** and you are all welcome, regardless of where you work.



Rail Wellbeing Live
17 & 18 November 2021

CHOOSE FROM 75 FREE SESSIONS TO HELP YOU LIVE A HAPPIER, HEALTHIER LIFE

Rail Wellbeing Live is a chance to get together online to focus on our health and wellbeing.

It's a two-day virtual 'pick and mix' event where you can dip in and out when you like, picking sessions that are the most relevant and interesting to you.

Get practical tips on things like work-life balance, eating well and coping with stress. And learn exercises to help with everyday aches and pains.

Celebrity speakers include British Olympic medallist Rebecca Adlington OBE, who will answer your questions on what she's learned about maintaining a healthy work-life balance. Plus, former Royal Marine Jason Fox will tell us what he's learned about coping in challenging times. Bryony Gordon, author of *Mad Girl*, will be delivering a session on mental health called 'No such thing as normal!'. You can also hear from Dr Rupy Aujla, who will be sharing hacks for eating well on the go.

Registration is FREE.
Sign up **by 30 September**
to win top prizes

- Pack of ten British Military Fitness classes*
- Fitbit Luxe
- Lululemon Reversible Yoga Mat
- 20kg Spinlock Dumbbell Weight Set
- One-year subscription to Men's Health OR Women's Health magazine

Recognise an exceptional colleague by entering them for the Wellbeing Hero Award

Scan the QR code and register today

Rail Wellbeing LIVE
Inspiring healthy lives across the railway

*Please check there is a convenient class near your home before entering the prize draw.

www.railwellbeinglive.co.uk

ZERO Defects Handover

Millbrook Station Footbridge Completion

Congratulations to our team at Millbrook Station who have handed back the new footbridge with zero defects, despite the numerous challenges presented by this complex scheme that was sandwiched between a main transport artery and residential properties. Although Millbrook Station is an un-manned station with limited stopping trains, it is a critical junction on the national freight network at Southampton Port, with frequent freight and passenger train movements from the large interchange station of Southampton Central.

For over three years the original Exmouth type footbridge had been structurally propped causing risk to the line. Our team installed a temporary footbridge to allow the life-expired structure to be safely removed and a new steel footbridge to be installed.

Numerous logistically challenging activities have resulted in services being transferred to the new footbridge, the relocation of CCTV and electrical cabinets and new passenger systems.

Congratulations to ALL involved, including our specialist suppliers, with special thanks to **Project Manager Brian Palmer and Supervisors Noel Ford and Peter Rogers.**

Thank you for your commitment and perseverance on such an important and challenging infrastructure scheme that has eliminated the risk to the line at this critical junction.

Brickendon Lane **Quality Stakeholder Engagement**

We are currently constructing a new retaining wall and carrying out culvert repairs at Brickendon Lane for Hertfordshire County Council where an existing embankment has moved.

Brickendon Lane is closed for the duration of the works with alternative routes signed, vegetation has been cleared and enabling works completed. Resident badgers have been sensitively relocated to another sett under licence from Natural England and all works adhere with the Environment Agency Permit.

Thank You Team, for your enormous efforts in keeping the local residents well-informed on your site activities and timings. This scheme has a significant impact upon them, and your communications are helping to minimise disruption and ensure the works can continue as efficiently as possible.

Modular Car Park Specialist Design Savings

Institution of Engineering and Technology, Stevenage

At the Institution of Engineering and Technology in Stevenage our specialist car park team are advancing at speed with the new modular car park that is providing significant savings in cost, time and space to our customer.

When the original multi-story scheme went to the planning officer it was recommended for refusal as it was thought to be too imposing for the area. However, using our specialist services with Siderpark, we developed a solution for a single deck structure that provided the same number of spaces with a cost saving of 30%.

This time the planning officer immediately recommended the scheme for approval. Also, with the savings made on the scheme the Institution will be able to resurface their entire car park which they could not afford to do previously.

Siderpark assembled the basic structure in just over two weeks, and a deck pour is programmed for later this month. The scheme will provide 19 electric vehicle charging points, and is also future proofed with the installation of ducts to every space on the ground floor to allow for more charging points as they become needed. Again, this has been paid for with the savings made by the revised scheme design.

Please do take a look at our website for a great case study on a similar car park design that also demonstrates how early engagement with a modular car park specialist can shorten the procurement period, save cost, and potentially save land.

Case Study - Modular Car Park Specialism Savings

Improving Access to the Underground Network

Step Free Access at Wimbledon Park Tube Station

The Step Free Access Scheme at Wimbledon Park Tube Station is our third of four underground stations that has now opened for use by the travelling public, enabling those with accessibility needs to use the station and the wider transport network with greater ease.

The station is now served by one lift and a high-level walkway linking it to the ticket hall, which provide access to the central platform for both east and westbound District line services.

This brings the total number of London Underground stations with step-free access to 86, with our Ickenham and Debden schemes having become step-free earlier this year.

Congratulations to the Project Team, including our customer and valued suppliers. For working together to support the Mayor of London's commitment to a greener, fairer and healthier transport strategy for London.

Charity Run for **Stripey Stork**

Good luck to Nikolaos Sapounas, Developments Financial Controller, John Fernandez and Communications Coordinator, Esther Pellow who on the 19th September will be running in support of our Osborne chosen local charity for this year, Stripey Storks.

The annual running event attracts hundreds of keen runners to raise much needed funds for local families who are facing hardship. Stripey Stork also collect toys, clothes and essential items for babies and children, that are rehomed to those most in need. Niko commented;

"It will be my third time participating in Run Reigate, and my goal is to finish the 10K in under 1 hour… it will be a great opportunity to give back to the community."

If you would like to support our runners and this great cause, please speak with them directly for details of their Fund-Raising page. Thank you.

Period 4 **GOLD Rated Sites**

Congratulations to our High Voltage Feeder Renewals Team who were awarded the Period 4 top scoring GOLD, for their exemplary behaviours and quality delivery of the project.

The team have worked closely with the communities, cleared up after others, and considered the environmental impact over the 11 miles of troughing and HV cabling replacements – whilst also safely completing a high-quality scheme that will provide greater resilience of the railway.

A Massive Well Done to ALL involved!
These awards are only given to the best sites across Network Rail - not just our Framework, but across the whole country.

Kings Langley Human Sundial

Benefitting Local Schools

Thanks to our team at Gade Valley, people in the village of Kings Langley can now tell the time just by looking where their shadow falls.

Working with local astronomer Dr Gerard Sheldon, our team have successfully constructed a "Human Sundial" to bring his amazing idea to life.

Encouraged by his teacher wife, Dr Sheldon wanted to help local school children to embrace science and to learn about how the earth moves in relation to the sun.

With the support of the Parish Council, the Human Sundial has now been created within Kings Langley Common and is available for young and old to enjoy. The clever layout of numbers and letters mean that when you stand on a spot that represents the month of the year, your shadow falls over markers that indicate the time. Brilliantly clever as well as being a beautiful feature!

Despite being delayed due to Covid restrictions, the sundial will now be officially opened later this month ready for the Kings Langley Carnival.

Thank You Team Gade!

For supporting the communities in which we work and helping to inspire our future engineers with the enjoyment of science!

Great Relationships at The Retreat

Supporting Local Charities and our Team

Our team at Gade Valley have certainly been busy supporting the communities in which we work, and in thanks for their kindness, a particular charity is making their life much easier too.

Over the course of the project our team have been supporting "The Retreat" in Kings Langley, carrying out exterior maintenance works such as painting, pointing and small brickwork tasks. This summer has been no exception and they have just completed much needed fencing around the estate.

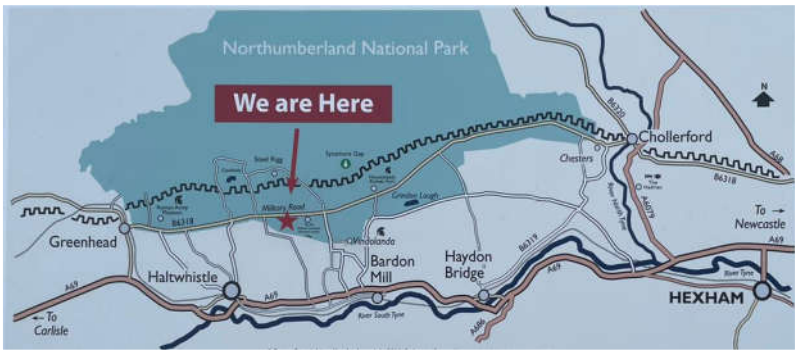
The Retreat is home to "The Book Trade Charity" through which the book trade helps colleagues in need and encourages fresh talent to join. They provide housing and grants and can support in areas such as social welfare and critical illness; https://www.btbs.org/

Through their great relationship, "The Retreat" allow our team to use their private access to gain entry to the bridge structure and viaduct span that cross over the West Coast Main Line. They also allow our team to store plant and materials during rail possession works, providing considerable time savings and methodology efficiencies. A win-win for all!

Thank You and Well Done Team Gade!
Through your kindness and consideration, you have created a meaningful relationship that helps support the local charity and our site works.

100-mile Hadrian's Wall Charity Ride

For St. Rocco's Hospice



Enormous congratulations to Peter Collins, Chris Charnley, Jamie Harrison and Costain's Tim Leather, who recently completed another gruelling "Coast to Coast" cycle ride, raising over £3000 for St. Rocco's Hospice in Warrington.

With the weather on their side, they successfully cycled the stunning 100-mile route of Hadrian's Wall, from the west Coast at Solway in Bowness, finishing on the east coast in Tynemouth.

The Hospice is close to their hearts and provides end of life care to those diagnosed with a life-limiting disease.

If you would like to support this great cause the team would be immensely grateful. Please speak with Peter, Chris, Jamie or Tim directly for details of their Just Giving page.

Thank You All! For your admirable support of St. Rocco's Hospice that makes a huge difference to so many lives in their time of great need.

Let's Talk about Dementia

World Alzheimer's Day – Tuesday 21 September 2021

World Alzheimer's Day is on 21 September each year and September is World Alzheimer's Month™. This year, they are talking about dementia and urging everyone to join in the conversation by becoming Dementia Friends.

The Statistics…

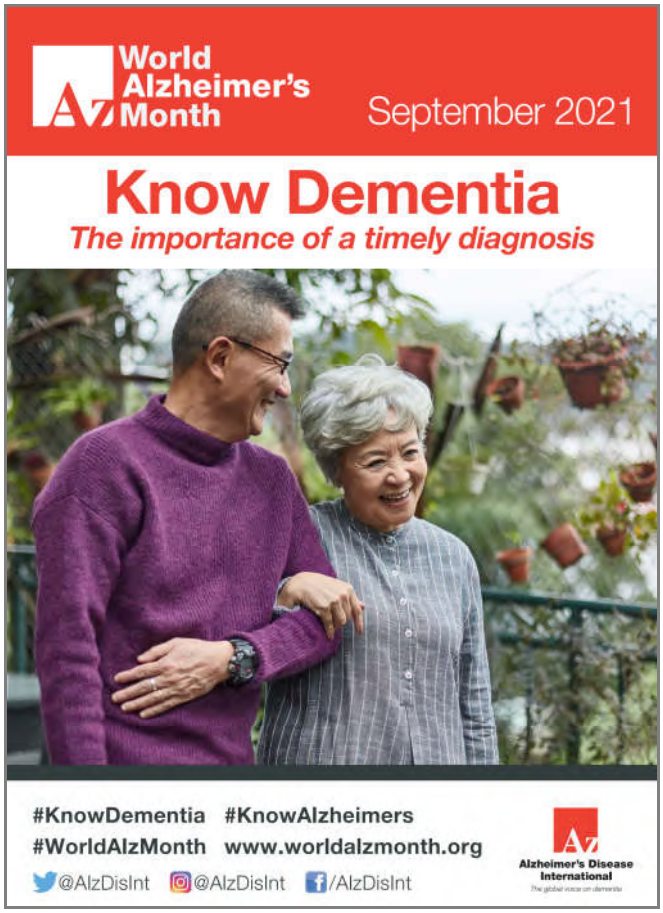
There are over **50 million people** around the world living with dementia.

The number of people living with dementia is predicted to treble to **152 million** by 2050.

The cost of dementia in the UK is expected to more than double in the next 25 years, from £26bn to **£55bn in 2040**.

Talking about dementia helps tackle the stigma and encourages people to find out more and seek help and advice.

- Families affected by dementia are facing an illness that's often frightening and debilitating. They shouldn't also have to deal with ignorance, thoughtlessness and cruelty from the people around them.
- Carers often have to deal with rude comments or stares while out in public with their loved one.
- People with dementia can experience unpleasant jokes or thoughtless comments from people who just don't understand the realities of their condition.



It is important that earlier diagnosis is made to ensure that people living with dementia and their care partners can live as well as possible for longer and access the support that they need.

Reducing the Risk of Dementia

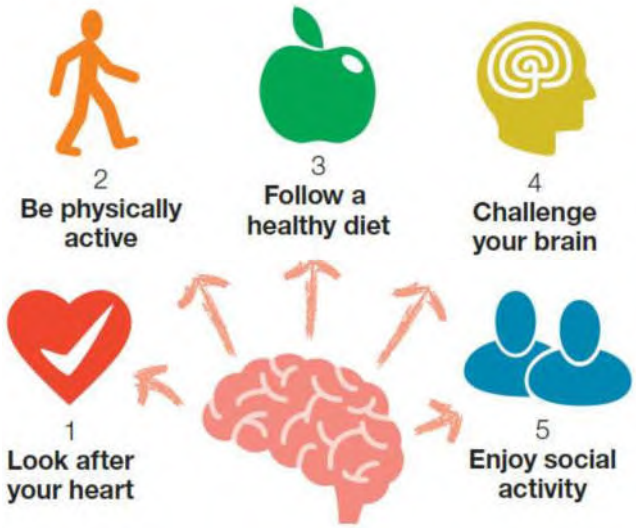
According to recent studies, one in three cases of dementia could be prevented if more people looked after their brain health throughout their life.

What is good for the heart is good for the brain.

Look after both with a balanced diet, and regular physical and mental exercise.

Although dementia is often only diagnosed in later life, the brain changes usually begin to develop years before. Acting early can vastly improve life for people with dementia and their families.

Lifestyle can play a major role in reducing an individual's dementia risk by strengthening the brain's networks to help it to function in later life despite damage. Reduce your risk of developing dementia;



Look after your Vision and Hearing

National Eye Health Week – 20 to 26 September 2021

Our campaign for September aims to raise awareness and understanding of how to protect your hearing and eyesight in association with the NHS;

Looking after your Vision and Hearing

The Statistics…

Every **6 minutes** someone is told they are going blind.

There are **12 million people** with hearing loss across the UK, around one in six people.

1.1 billion young people are at the risk of hearing loss due to exposure to noise in recreational settings.

As we get older your vision may change in the following ways;

- Blurred vision
- Reduced visual field
- Trouble judging distances
- Taking longer to adjust to changes in lighting levels

This year's National Eye Health Week is set to take place from the 20th to 26th September 2021 and aims to inspire and educate people on the importance of eye health and why they should go for regular sight tests.

- A sight test can detect early signs of conditions like glaucoma, which can be treated if found soon enough.
- During a sight test, other health conditions such as diabetes and high blood pressure can be detected.

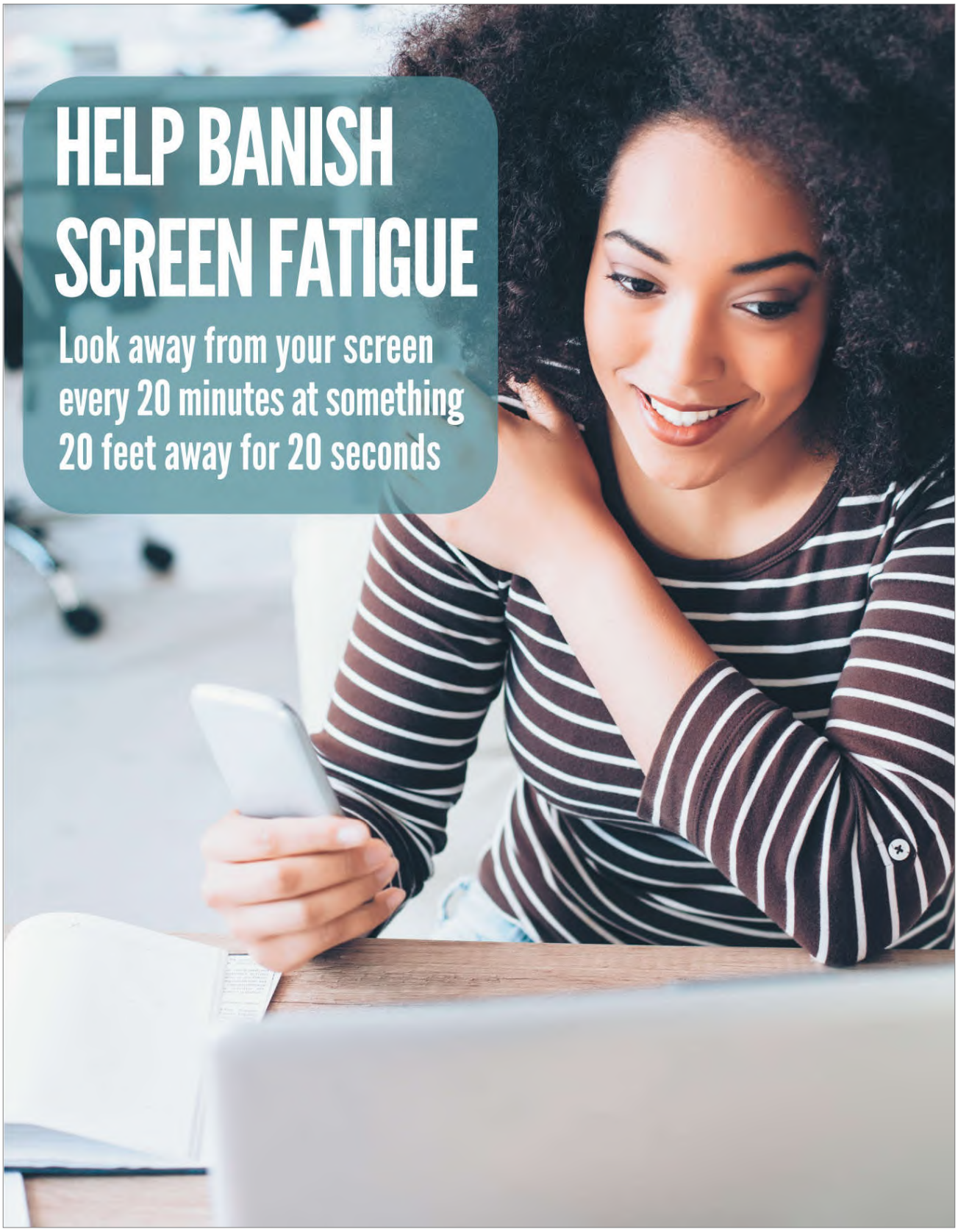
Sight is the sense people fear losing the most, yet many of us don't know how to look after our eyes – National Eye Health Week aims to change all that!

You can look after the health of your eyes, and help to prevent eye conditions from occurring, by:-

- Not smoking
- Keeping active
- Eating a balanced diet
- Protecting your eyes from the sun
- Having regular eye checks

For more information visit the Vision Matters website;

Your Vision Matters


HELP BANISH
SCREEN FATIGUE
Look away from your screen
every 20 minutes at something
20 feet away for 20 seconds

Hearing

Problems with hearing can affect the balance centre in your inner ear, and your awareness of hazards in your environment, making tripping and falling more likely.

If you've noticed a change in your hearing, speak to your GP as soon as possible.

If you suffer from hearing loss, hearing aids are available free on the NHS and can help restore some, if not all, of your hearing. Think about how you currently look after your vision and hearing;

- What positive things do you already do to look after your vision and hearing?
- What changes can you make that might help?
- How will you make these changes?

You can find out more about how to best protect your vision and hearing by visiting;

Looking after your Vision and Hearing

World Suicide Prevention Day 10 Sept '21

CALMDriver Initiative

125 LIVES LOST TO SUICIDE EVERY WEEK

Every single day 18 people lose hope.

Every week 125 see no future.

Every month 500 people feel like too much of a burden on loved ones.

Every year 6000 people decide the world is better off without them.

Every day, someone wishes they could have said something.

This World Suicide Prevention Day we want everyone across the UK to know that someone wants them to **stay**.

Every week 125 people in the UK take their own lives and 75% of all UK suicides are male, like the overwhelming majority of van and truck drivers.

CAMPAIGN AGAINST LIVING MISERABLY CALM

Driving alone all day, the stress of battling with the clock and congestion, do not make things any easier.

So, Highways England and Driving for Better Business have teamed up with CALM to help drivers through tough times.

Driver Support Pack

Together they have created special vehicle packs containing a simple flyer together with discreet stickers, so that drivers easily know there is someone there to talk to, every day, if they are struggling. For more information on the CALMDriver campaign visit;

CALMDriver "Stay" Campaign

STAY.

(The #CALMDriver scheme with Campaign Against Living Miserably has been recognised, winning the award for Outstanding Product or Service at the Fleet News Awards 2021.)

Toolbox Talk - **Wasps**

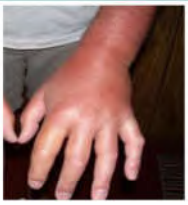
Infrastructure Projects Southern

Toolbox Talk

Wasps

23 June 2017

Did you know?



Last year there were seven incidents of wasp's stings. For example an operative suffered multiple wasp stings whilst carrying out devegetation works, when he stood on a wasps nest.

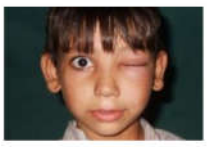
Wasps release a chemical alarm to each other if they are disturbed or feel in danger this causes the nest to swarm and react. Wasp nests can carry up to 10,000 wasps which can be found in hidden locations underground, insides bricks, walls and hedges.

Why do they attack?

Wasps can attack unexpectedly attack at any time. They sting to protect themselves and their nests. If they feel angered, threatened or disturbed they will attack.

What are the symptoms of a sting?

The most common symptoms:



- Pain in the area of the sting
- Minor swelling and redness
- Itchiness.

Anaphylaxis

Some symptoms that develop may signal a severe allergic reaction, this can include the following:

- Difficulty breathing and swallowing
- Dizziness, fainting, nausea or vomiting
- Increased heart rate
- Rapid and severe swelling.

Seek urgent medical attention if you experience a severe reaction or if you are worried about a reaction

How do I treat nests?

Treating a wasp nest can be very dangerous and it is important to use a trained professional for safety. Contact a professional PEST control company.

Do not attempt to treat a nest yourself

Do

- ✓ Report any harm or injury by wasps or if you suspect a wasps nests in the area
- ✓ Keep calm and still to avoid being stung
- ✓ Stop any works that are being carried out in the vicinity of a wasps nest. Cordon off the area and treat the nest as soon as possible
- ✓ If you are allergic to wasp stings please let your line manager and team know.

Do not

- × Make any sudden movements around wasps
- × Scratch or rub the area that has been stung, to reduce the risk of infection
- × Remove a sting with tweezers to avoid spreading venom. Scrape it out sideways using a sharp edge e.g. a credit card
- × Approach or attempt to destroy a nest.

This and other toolbox talks can be downloaded from:

www.southernshield.co.uk

Contact us: shield@networkrail.co.uk

SHE Performance Summary – July 2021

Improvement Opportunities Frequency Rate (IOFR) the Current Rolling IOFR is: **2.90**
(Target of 2.5 per 1000 hours worked)

Accident Frequency Rate (AFR) Days since the Last RIDDOR Accident: **168**
The Current Rolling AFR Is: **0.12** against a threshold of 0.01

Service Strike (SSFR) Days since the last Service Strike: **22**
The Current Rolling SSFR is: **0.43**

July Total Number IOs	July No. Safety, Health & Environmental IOs	July No. Business IOs
371	342	29

Reference Number	Date	Project	Description
Operational Close Call			
13692021-23-07	23/07/21	Sussex Planned and Reactive	Signaller did not provide the correct signal protection when the Competent Person was walking out to place protection (not Osborne incident).
Service Strike			
12982021-08-07	08/07/21	A46 Binley	Communications cable and duct struck by machine bucket – working within exclusion zone.
13032021-09-07	09/07/21	Essex Road Bridge	Pot-ended electric cable struck – insufficient service drawings provided by the service owner.
TM Incursion			
12652021-05-07	05/07/21	A46 Binley	MOP vehicle cut across centre of roundabout where personnel were working, at speed. No injuries.
13862021-27-07	18/07/21	Connect Plus Denham	MOP vehicle was being escorted through the closure, when it broke away from the escort and drove through at speed.
13722021-23-07	22/07/21	A46 Binley	MOP vehicle entered closure at roundabout exit and drove up to works. Did a U-turn and exited when route was blocked.
13622021-21-07	21/07/21	A46 Binley	Whilst being pursued by police, MOP drove through taper cones and through works – no injuries.
13712021-23-07	23/07/21	Connect Plus Lifecycles	Vehicle lost control when accelerating and struck safety barrier.
13922021-30-07	30/07/21	A46 Binley	HGV drove into works entry in error and reversed out on to live carriageway before it could be escorted.
13932021-30-07	30/07/21	A46 Binley	MOP drove into works entry in error and was stopped and escorted through works.
Property Damage			
12662021-06-07	06/07/21	Clapham Jcn Station	Fire broke out on Clapham Junction Station due to track circuit cabling fault (not Osborne works)
13602021-20-07	20/07/21	Kent Planned and Responsive	Over height barrier at car park entrance was blown into van roof.
Near Miss/Close Call			
13022021-09-07	09/07/21	OTW Liphook	Birds nest with eggs found on stored tower scaffold – exclusion zone set up.
13382021-19-07	09/07/21	A46 Binley	Excavation dug too close to carriageway and not in accordance with design.
13162021-14-07	14/07/21	LUL Wimbledon Park	Mobile scaffold tower used within 1.25m of platform edge without railway protection in place.
13822021-27-07	25/07/21	Gade Valley	MEWP became stranded whilst at height requiring rescue from another MEWP.
Other Classification			
13882021-27-07	27/07/21	Kent Planned and Responsive	Operatives not wearing face coverings whilst working in Ashford IECC.

Improvement Opportunities

August IO Statistics

During the month of August, the level of engagement with the IO System has again reduced when compared to the same time last year.

The IO panel noted several incidents of people not wearing the correct PPE. Please proactively check all PPE on your sites and ensure that any concerns are resolved immediately.

Improvement Opportunities are critical to our learning culture and to ensuring everyone returns home safely every day. Please do continue to submit your IO's and thank you for recognising the importance of your continued engagement.

Top Suppliers in August

- RJ Power Group Ltd 7
- Deploy (UK) Rail Ltd 5

Top Projects in August

- Gade Valley Strengthening 46
- A46 Binley 45
- OTW E&P Northbrook 27
- Yeovil Pen Mill North Embank't 22
- White Hart Junction 21

Top IO Originators in August

- Hakeem Ali 29
- Alastair Howell 26
- John Bowers 22
- Cam Jones 18
- Henry Barkas 18

Top SHE Categories in August

- Access / Egress / Site Security 53
- Site Housekeeping 37
- Personal Protective Equipment 18
- Sie Welfare 16
- Tools and Equipment 15

Infrastructure Improvement Opportunities		
Month	Total No. IOs	Total No. People Raising IOs
June	353	78
July	371	75
August	336	72
How many did your site submit last month?	?	?

Safety Advice

Action required following a serious incident

everyone home safe every day

Safe use of ballast brushes

Issued to:	**All Network Rail line managers, safety professionals and accredited contractors**
Ref:	NRA21-11
Date of issue:	28/07/2021
Location:	Warminster, Wessex Route
Contact:	Malcolm Miles, Network Technical Head - Plant

Overview

On 26th February 2021 at 01:21hrs, a member of staff was acting as a Machine Controller (MC) for a Road Rail Vehicle with a ballast brush attachment.

The individual was struck by a ballast stone that was ejected by the ballast brush. It caused a significant, life-changing injury to the left eye and cheek bone.

The MC was standing ahead of the machine and outside the exclusion zone at the time of the incident. He was not wearing eye protection.

The ballast brush had been maintained by the supplier before delivery to this site, replacing some missing/damaged tines but not the damaged and shortened rubber skirts that are intended to contain ballast during operation.

The ballast brush was being used in deeper ballast and with faster forward speed than designed.

While the investigation is concluded and we agree design improvements, all operators and machine controllers must implement the following control measures.

Immediate action required

- Pre-delivery and pre-use inspections must be undertaken to ensure that there is no damage to the skirt. Any brushes found to have defective skirts shall be quarantined.
- Ballast brush skirts must provide maximum coverage. Only brushes with a single 3rd rail cut-out can be used in 3rd rail areas. Cut-outs are not allowed for other areas.
- Shift plans for using ballast brushes in 3rd rail areas must allow sufficient time for an additional pass through the site: one in each direction.
- Machine controllers shall maintain a 30m exclusion zone around the machine whilst the ballast brush is in operation. If the machine controller needs to inspect the track in advance of the machine due to obstacles or deep ballast, then the ballast brush shall be stopped whilst this is completed.
- Thorough site walk outs must be completed before any ballast brush operations are undertaken to identify any deep ballast areas that may cause the brush to dig in and any other obstacles/hazards that the MC needs to know.
- Assurance checks need to be completed to ensure the requirements of this safety advice are being complied with.
- Eye protection must be worn by all staff.

highways england

INFORMATION

Safety Alert

Failure of High Access Equipment

24 August 2021

Background information

- A team of three operatives were working at a height of approximately 7-8 metres underneath a viaduct.
- The operatives were competent trained rope access personnel, working from a steel cable. Each operative was attached via a harness whilst installing brackets for ducting beneath the viaduct.
- One end of the cable was anchored using a carabiner that was calculated and adjusted to hold the correct weight.
- The carabiner failed whilst the operatives were working causing them to fall to the ground.
- One operative landed in the canal, one suffered a broken ankle and one had a broken wrist and femur.
- All involved (including all site personal and family members) have been offered support from the contractor and Highways England.

Investigation

- A rope specialist has been brought in to carry out a full investigation and to help us understand why the carabiner failed and help improve future operations that are conducted within the same way.
- Highways England are working closely with the contractor and HSE to establish all the facts and offer support where necessary.
- The investigation is ongoing and lessons learnt will be shared once all information is gathered.

Remember

- Follow an approved Code of Practice for rope working (in this case IRATA).
- When working on high level access equipment, ensure that a specialist is on hand to;
- **Plan** the works thoroughly and note within the RAMS. ***Ask your ropes specialist to review the RAMS paying particular attention to the provision of a separate safety line for each operative.***
- **Manage** the works continually to follow the RAMS, any changes to be signed off by a supervisor.
- **Monitor** – ensure correct supervision of the job throughout the process.
- **Assurance and audit systems -** reviewed to obtain positive affirmation that that current risk assessments, procedures and processes are being followed correctly

Don't Walk By

- If something doesn't look right, or feel right, or you believe there may be a different /better way to do something, stop the job and speak up.

If you have any queries about this safety alert information announcement or any other safety announcement then please contact **Neil.Tyson@highwaysengland.co.uk**

HEi266

home safe and well

Safety Bulletin

A serious incident has taken place

everyone home safe every day

High Pressure Jetting Accident.

Issued to: Works Delivery Kent & Sussex Route

Ref: WDSER18AUG01

Date of Issue: 18/08/21

Location: CAT 460 Overbridge, Brockley.

Contact: Huw Abbey

Overview

On Sunday 15th August, a contractor working for the Works Delivery Civils team was injured while carrying out high pressure jetting of bridge structure CAT 460 to remove old paint coatings and defective metal elements in preparation for re-coating.
Initial reports suggest the IP tripped and fell backwards over the con rail and dropped the lance he was using and the residual pressure jet hit him in the left hand side rib area. The IP has sustained skin lacerations and a broken rib, received first aid on site by Paramedics and was then taken to Kings College Hospital where he received pain management and spent 2 nights there.
The accident is still under investigation however the following initial learning points have been identified:

- The jetting equipment has an auto cut-off so maintenance records and equipment will be checked as part of the investigation.
- Ballistic PPE was in use which should prevent such injury so compliance and condition of PPE will be checked.
- Competencies & Training records to be checked for team members using the equipment.
- Pre work site clearance was undertaken but could more have been done to improve the underfoot conditions?

Discussion Points

While the investigation into the incident is ongoing, please discuss the following with your team;

- Always check plant before use including maintenance records.
- Carry out pre-work checks to ensure PPE and Specialist equipment is in functional condition .
- Have all efforts been made to improve site conditions where feasible?

Part of our group of Safety Bulletins

Safety Alert | Safety Bulletin | Safety Advice | Shared Learning

Tideway

LESSONS LEARNED

HSW

Facial Injury from Grinder Handle

INFORMATION ONLY

Activity: Cutting 9m prefabricated rail sections into 4.5m sections to be used to extend the rail track along the curve in MNTLD.

Date of incident: 17/07/2021

Consequence: IP suffered a cut to the chin and a graze to the left cheek – Non-Lost Time Injury

Potential consequences of recurrence:

- Lost Time Injury

The incident:

- The IP (an experienced Fabricator) was cutting rail sections using a 9" grinder at Pit Top.
- The rail sections required cutting from 9m to 4.5m to accommodate the tunnel curve.
- The rail section was laid down on timbers on the floor so that it was supported and in an accessible position for the Fabricator to carry out his work.
- Whilst cutting the section the grinding disc snagged in the cut causing the grinder body to kick upwards, knocking up the IP's visor and making contact with his face and chin.

Main Findings

Root causes of incident:

TOP RISKS

- **Safe System of Work** – The approved RAMS stipulated that a 9" grinder was the suitable tool to be used for cutting steel, however there were no specific details related to cutting rail sections. The RAMS covers a wide range of cutting / grinding / welding / maintenance tasks undertaken by the mechanical team and is not specific to one activity.
- **Planning / Communication** – This was the first time this activity had been undertaken on site and personnel were not aware that a rail cutting Stihl saw had been procured a long time ago and was available on site for this task.

Contributory causes:

- **Tools & Equipment** – There were a mixture of 9" grinders on site – some anti-kickback and some not. The one used for this task was not an anti-kickback model. The rail cutting Stihl saw was not used.

Page **1** of **2**

Tideway

LESSONS LEARNED

HSW

Learnings & Recommendations

Preventative actions:

TAKE ACTION

- **Safe System of Work** – The RAMS which covered this activity have been revised to include more detailed instructions and control measures for cutting rail sections. While the RAMS covers general activities for the mechanical team, the detail for each specific task will be covered in the Point of Work Risk Assessment and briefing.
- **Control of Grinders** – Cutting discs are now stored in a locked box and only issued out by Mechanical Chargehands. A Point of Work Risk Assessment must be completed in order for the disc to be issued.
- **Use of Correct Tool for Task** – The rail cutting Stihl saw has now been specified in the RAMS and is available for use on site (see image below).
- **Tool Standards** – All anti-kickback grinders have been quarantined on site and are awaiting removal. The Procurement department have been informed of the specifications that all grinders purchased for the project must comply with (which includes the requirement to be an anti-kickback model). Details of the new standards on the project have also been shared with the MWC parent companies and our supply chain.

Minimum Standard for Grinders

Minimum safety requirements for angle grinder **MUST** include:

- Deadman or paddle switch (switch must have constant pressure)
- Kickback Protection (if disc jams – it stops)
- Re-start Protection (prevents the grinder from unintentionally starting if power is temporarily lost)
- Multi position Locking Guard (positioned to protect the user)

Further **recommended** safety features:

- Anti-Vibration handles
- Soft start up
- Multi position handles
- Electronic overload protection

Capital Delivery Alliance
Cynghrair Cyflawni Cyfalaf

Safety

Immediate Action Required

Red - Action

One Day Lost Time Injury

Summary:

An Alliance operative suffered a laceration injury to his neck which resulted in twelve stitches being applied at A&E to close the wound.

Details:

The Injured Person (IP) was using a STIHL TS410 Cutting Machine to cut through a 150mm concrete pipe in a 2m x 2m excavation. PPE being worn consisted of a Versaflow TR-300+ with M-300 head top.

As the IP was cutting the pipe, the Machine has suddenly 'kicked back' and the adjustment lever above the blade guard has struck the IP beneath the chin. The lever had 'teared' through the Versaflow dust shroud and caused the injury.

The direct cause of the laceration has been identified as a 'cable tie', there is conclusive evidence that one was present on the end of the lever while the machine was being used. This has been corroborated by the IP as the reason why the Versaflow shroud was ripped and why the laceration occurred.

Action to be taken

- Conduct Toolbox Talks with all tool users and stipulate that cable ties and any hazardous items attached to a tool are removed before use.
- Update risk assessments where required to ensure that a selection process identifies the lowest risk tool for the task, take into account ergonomic, environmental, materials and user considerations.
- Conduct a site audit of all tools/equipment and ensure all items attached which could present a hazard (such as cable ties) are removed.
- Engage with your supplier to remove the use of cable ties for attaching delivery documentation to hired equipment. Remove the risk and the need for single use plastic.

WWCA – **RA13** Issued by: The Alliance H&S Team Dated: **03-08-2021** Display Until: **03-09-2021**

Capital Delivery Alliance
Cynghrair Cyflawni Cyfalaf

Immediate Action Required

Learning

- **The use of a STIHL machine for the task:** Although widely used in the construction industry for a variety of cutting tasks, many including cutting cementous products such as blocks, bricks, pipes and sheets. **There are many cases where safer alternatives can be used, such as pipe breakers, grit saws etc.**

- **Ergonomic Position:** The IP would have been in a bent forward position to reach down to the pipe at ground level, this would have impacted his natural balance and control during the cut. It has resulted in the IP's upper body being drawn closer to the STIHL machine than would normally be seen in a standing position and when cutting at waist height. **In selecting tools for tasks, the positioning and ergonomics of use must be taken into account.**

- **Cable Ties:** It has been established that cable ties are used and were being used at the time of the incident to attach delivery documents to the STIHL machine. In hindsight the danger posed by these items, particularly in prominent positions such as on adjustment levers, was overlooked. It had become 'common practice' to remove document wallets from delivered equipment and not the cable ties, this has been confirmed through a site wide audit of similar equipment. **This accident demonstrates that cable ties left on tools, particularly in prominent user facing areas, can be a hazard.**

Communication			
Brief to Site Personnel	✓	Brief to Office Personnel	
Brief to Supply Chain	✓	No Briefing Required	
Display on Notice Boards	✓	Forward to Supply Chain	✓

Dŵr Cymru Welsh Water · ARCADIS · SKANSKA · MMB Mott MacDonald Bentley · ARUP · Morgan Sindall Infrastructure

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ACTION

Safety Alert

Product Recall of STIHL TS 410 & TS 420

13 August 2021

Background information

This Safety Alert has been produced in the interest of your personal Safety

- STIHL has learnt that a limited number of TS 410 and TS 420 cut-off machines in the below noted serial number range were assembled with the flywheel-to-crankshaft connection over-tightened. Overtightening of this connection may damage the flywheel, which could cause the flywheel to fail and break apart while the engine is running.
- A failure during the operation of the machine would pose a **projectile hazard** to the user or a bystander. A damaged flywheel is not apparent from a visual inspection
- **Machines in the following serial number range are affected: 189442634 – 190001700**
- If you own a cut-off machine TS 410 or TS 420 in this serial number range, please discontinue using the machine immediately

Actions

- If you have identified your Stihl Saw product is one of those within the stated recall serial numbers, do not use it.
- Contact your local STIHL dealer for a flywheel replacement. This repair is free of charge for you.
- Link to your nearest Stihl Dealer https://www.stihl.co.uk/dealer-locator.aspx

If you have any queries about this safety alert information announcement or any other safety announcement then please contact **Ian.Clayton@highwaysengland.co.uk**

HEi265

home safe and well

Highways Division Safety Bulletin

Issue no: HS/HWSB/ 077
Page 1 of 1

SkillSearch On-Line Ref: HWSB077

Date: 17 August 2021

Highways England Safety Alert HEi265

This Bulletin is issued to the Highways Divisional Director and Agents. It must be communicated to personnel responsible for planning and supervision.

Agents are also responsible for communicating this bulletin to staff and relevant members of the supply chain.

Summary

Highways England have recently issued a new safety alert HEi265.

The new alert covers a product recall of a range of STIHL TS 410 and TS 420. The alert requires all projects to review and report back onto the Client on their Airsweb system before 17th September 2021. Supplementary notes have also been provided on how to enter the details onto Airsweb.

Details in the alert.

The HE alert provides background information and details, on STIHL product TS 410 and TS 420 cut-off machines within a set serial number range that have been identified as having assembly faults with flywheel- to -crankshaft, which could cause the flywheel to fail and break apart during operation potentially causing a projectile hazard.

Machine serial number range affected are 189442634 to 190001700

It maybe possible that we or our supply chain are operating machines within this recall range. For this reason, please brief out this and the Highways England alert to our staff and supply chain.

To help ensure that the message has reached those likely to be affected we and Highways England are asking each project to confirm the briefings have taken place prior to 17th September 2021.

- To confirm the briefing to Highways England on their AIRsweb system that the issues identified within the Alert have been checked and verified on your project. This is to be referenced on AIRsweb - incident HEi265 - Highways England for Action Safety Alert - Product Recall of STIHL TS 410 & TS 420
- To confirm to BAM Nuttall by email to mark.lowe@bam.com that the briefings have been briefed and recorded on HE AIRsweb.

Full details of the above Highways England alert and guidance on AIRSweb reporting can be found on the Nuttall Hub.

If you have any questions or cannot access the Nuttall Hub please contact your Area Health and Safety advisor or alternatively email safety@bamnuttall.co.uk

YOUR SAFETY IS MY SAFETY - The Rules

KIER

Urgent attention required

SHE alert

Safety • Health • Environment

Ref: SHE/A/2021/H199
Issued by: Kier SHE Department
Date: 10/08/2021

Unsafe manhole cover

What happened?

Whilst strimming a sightline which was heavily overgrown, an operative stepped into a partially open manhole causing him to twist his knee and bruise/graze his leg. The operative received first aid and will return to work with no lost time.

The manhole cover had become unseated leaving an open gap which was hidden by the dense vegetation.

Before clearance

After clearance

After remedials

What can you do to avoid a similar incident?

- Request and review any asset information prior to works commencing – look for possible hidden hazards such as manholes, gullies, cables etc.
- Check your access arrangements before starting work. Make sure that plant and personnel can get safely to and from the work area.
- Always follow your Safe System of Work (SSOW)
- Check the work area (as far as possible) before commencing work to identify any hazards.
- Ensure previously unidentified hazards are recorded on your Point of Work Risk Assessment.
- Ensure everyone working on site is made aware of any hazards identified.
- Clearly mark physical hazards with cones, tape, or physical barriers.
- Ensure you are wearing all PPE required by your safe system of work.
- Maintain good housekeeping practices throughout the works.
- Probe dense vegetation or long grass with a survey pole or similar before stepping onto it.
- Be cautious when visibility of the ground is restricted and test the ground is solid before stepping forward.
- Check that coverings can take your weight and are stable before stepping onto them.
- If you feel unsafe or notice any new hazards, stop works and inform your supervisor.

NOTHING IS SO URGENT OR IMPORTANT THAT WE CANNOT TAKE TIME TO DO IT SAFETY

Safety Health Environment

SAFETY FLASH

Eastern Region

Subject: Anti-Vaccination and Anti-Mask Posters	**ID Code:**	Suffolk-SF-024
	Date:	16/08/2021

Description:

The Suffolk County Council's Growth, Highways, and Infrastructure directorate have made us aware of incidents occurring around the UK in which anti-vaccination and anti-mask posters have been put up which contain hidden razor blades. People have been injured where they attempt to remove the poster.

Figure 1 - Example of poster provided by Derbyshire NHS

It is not currently known whether these posters are present in Suffolk.

Actions Required:

SFRS staff are advised not to attempt to remove any anti-vaccination or anti-mask posters. Where SFRS staff suspect a razor blade is present, they should inform the police by calling 101 and submit a near miss.

Is a Service Action Note Required?	***Yes***		***No***	X
Communication of Safety Flash (Service)	*Internal*	X	*External*	X
Communication of Safety Flash (Personnel)	*All*	X	*Ops*	

Further information:

Authorised by:

Health, Safety, and Wellbeing Team

This safety flash should be displayed until 16/12/2021

Shared Learning

everyone home safe every day

Learning from others - a serious train accident near miss

Issued to: **Network Rail line managers, safety professionals and accredited contractors**

Ref: NRL21-02

Date of issue: 16/08/2021

Location: Chalfont & Latimer station, Metropolitan Line, London Underground

Contact: Investigation and Assurance

Overview

On 21st June 2020 at 21:43, a near miss occurred between two passenger trains at London Underground's Chalfont & Latimer station. A southbound Chiltern Railways train travelled towards a stationary northbound Metropolitan line train on the same track, and stopped only about 23 metres away.

The Chiltern Railways train had passed a signal at danger (a SPAD) and had been automatically stopped by a tripcock train protection system. The driver reset the tripcock and continued without seeking authority, running through a set of points and going too fast over a crossover onto the line occupied by the other train.

The driver decided to proceed without authority because he did not remember passing the red signal and believed the tripcock activation had been spurious. His training in how to use a safety system was inadequate.

No one was hurt but the points and signalling system were damaged, causing disruption.

The Rail Accident Investigation Branch (RAIB) report contains a lot of learning which is immediately relevant to Network Rail.

Underlying causes

The driver was probably fatigued. He suffered sleep apnoea (stopping breathing when asleep) and type 2 diabetes, both of which disturbed his sleep. This had not been recognised in the medical examinations.

The driver had a long history of safety events but gaps in line manager resource had contributed to ineffective action to address knowledge gaps and monitor performance.

Training and competence management were ineffective. RAIB commented about a safety brief using over 100 PowerPoint slides.

RAIB also found gaps in shared risk management between the different companies involved.

Key message

Line managers have a key role in monitoring safety performance. Frequently changing line managers, or coping with prolonged management gaps, has an adverse effect on safe working.

Competence management should take account of personal safety performance. Training must cover all aspects required to work safely.

Medical checks and fatigue management must consider sleep disorders and other factors beyond immediate shift patterns.

Safety Advice

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Capacitor failure at Waverley signalling centre

Issued to:	**Network Rail line managers, safety professionals and accredited contractors**
Ref:	NRA21-12
Date of issue:	19/08/2021
Location:	Waverley signalling centre
Contact:	Felix Langley / Colin Lamb

Overview

Edinburgh Waverley Signalling Centre recently suffered an incident where a capacitor in an Uninterruptible Power Supply (UPS) failed. The capacitor emitted smoke into the plant room, which spread to the Operations floor. The fire alarm was activated.

The incident led to the building being evacuated, with attendance by the fire brigade. There was severe disruption on the network, resulting in significant train delays.

Investigation has identified this UPS unit had been mistakenly removed from the annual maintenance inspection by the manufacturer (Vertiv) in 2017 and was not in Ellipse (it had previously been recorded in Ellipse). The capacitor had not been renewed since it was installed around 2001. The unit was a Vertiv Chloride EDP90, 80KVA unit.

Things to consider:

- Resilience of the network if a catastrophic failure occurs with critical equipment UPS equipment.
- Are adequate maintenance arrangements in place for critical assets?
- What age should capacitors be renewed? How do we inspect and maintain capacitors?
- Should electrical equipment be located away from operational buildings or are fire separation measures within the building adequate?
- Should fire suppression systems be installed within electrical equipment rooms?

Immediate action required

The following immediate actions must be taken across all Regions:

- Check all UPS units are in Ellipse with maintenance requirements correctly set up.
- Review UPS and capacitor age profiles and the criticality of each location to devise an action plan.

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Failure of small core (16mm diameter) WT Henley Polymeric Insulator

Issued to:	**DEAMs, Directors of Safety, Capital Delivery Directors and accredited contractors**
Ref:	Local Safety Advice NRA21-02
Date of issue:	30/07/2021
Location:	Chiltern Green, East Midlands
Contact:	Sultan Parker, Principal Engineer

Overview

On the 4th July 2021 an OLE insulator parted at Harpenden (Chiltern Green on East Midlands Route). OLE Maintenance staff were adjusting the balance weight pulley wheel separation and had applied lifting equipment "a rig" around the compensating plate between the anchor tail wire and the contact/catenary conductors.

When they released the tension after completion of works, they heard a 'cracking' sound coming from the existing balance weight small core (16mm diameter) polymeric insulator in the tail wire. Realising something was wrong, the OLE staff moved clear and the polymeric insulator then parted, causing the balance weight stack to descend to the ground releasing the OLE tensions.

Immediate action required

- Small core (16mm diameter) WT Henley insulators Catalogue number 91/012574, manufacturer reference 56145-56 are NOT FOR FUTURE USE. The larger core (31.5mm) WT Henley insulator Catalogue number 91/010050, manufacturer reference 56146-65 shall be used.
- Check and quarantine ALL small core (16mm diameter) WT Henley insulators 91/012574 from Stores.
- The WT Henley insulator Catalogue number 091/012573 manufacturer reference 56145-8 which are NOT installed in the line are also to be quarantined.
- Where 16mm core diameter insulators are already installed in the line (e.g. in balance weight tail wires) these insulators shall be replaced with the 31.5mm core diameter version.
- Where a 16mm core diameter insulator is found as part of a balance weight assembly it shall be replaced prior to performing any work on the wire run. Staff shall be cautious when applying the Rig (not to introduce any shock loading into the insulator).
- OLE staff are also reminded of previous Infrastructure Group Safety Bulletins (IGS) 266 and 276 relating to Double Clevis '808' components. In particular the requirements to inspect such components prior to applying lifting equipment "rigging" on balance weight or tensioning assemblies.
- The Safe Work Pack shall include hazard control measures to mitigate the risk of failure of such components during replacement.

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Vehicle fire involving Cyclon cell batteries

Ref:	WWB21-11
Date of Issue:	13 August 2021
Location:	Pontrillas
Contact:	Robert Knapman, Route Workforce Health, Safety & Environment Advisor

Overview

On the 7 August 2021, a colleague within the Signalling and Telecoms team was travelling from site when a fire occurred in the rear of their hire vehicle.

The fire is believed to have been caused by a short circuit from a single 2v 25ah Cyclon cell battery that had moved in transit against the bulkhead of the vehicle.

To prevent movement of the batteries in transit, the driver used their Personal Protective Equipment (PPE) to fill gaps in the cardboard box that the batteries were being stored in. The hire vehicle had no shelving so additional PPE was used to try and secure the box in the rear of the vehicle.

During the journey, the driver smelt burning and saw dark smoke in the driving cab.

The driver opened their windows, turned on their hazard lights and safely parked the vehicle.

The driver opened their rear door and discovered large flames in the back of the vehicle. They put the fire out by pulling their burning PPE onto a grass verge and stamping out the fire.

The driver sustained a minor burn to their right hand and the vehicle sustained minor damage.

This accident is still under investigation. Further learning will be shared where identified.

Discussion Points:

1. What are the risks of transporting batteries?
2. How do you safely transport batteries?
3. Where would you look for safety information on batteries and other "dangerous goods" (i.e. fuels/ detonators) that may be a fire risk?
4. Small fires should only be tackled when safe and you are competent to do so. What would you do when discovering a fire?

Wales and Western

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02-2021

Podium Step Failure

Health & Safety Alert

Following a recent incident involving the failure of a Podium Step, we would like to share the findings to prevent a potential re-occurrence.

A TClarke operative was using a '1 Meter – Anti Surf Podium Step' when one of the front castor legs snapped, causing the Podium to fall forwards. Fortunately, the operative was working directly in front of a block wall, which broke the fall of the podium and he escaped unharmed.

The Podium Step was secured and then sent to the Podium Supplier's Workshop, for a thorough investigation.

The Suppliers report identified that the Castor Leg had 'cleanly' snapped off (on the circumference of the weld), on the right side (Image 2) and had a stress fracture to the Left Castor Leg as shown in Image 3.

The Suppliers conclusion assumed that a large excessive force had been applied to the Podium Chassis which had weakened the welds to a point where the right leg snapped off.

Whilst it was very fortuitous that the individual was unharmed, we can use this incident as a 'lessons learned' scenario to ensure we are able to prevent a re-occurrence.

This incident highlights the importance of undertaking pre-use checks before using Equipment, and to ensure the inspections are thorough and comprehensive. It may require taking a closer look at certain areas to ensure small details (As shown in Image 3) are identified.

Please ensure that a full review of all Access Equipment is undertaken following this Alert, and that all Podium Steps are closely examined for any potential weaknesses or defects.

Any damaged or defected equipment is to be taken out of use immediately and sent to the relevant parties to either be repaired or destroyed, depending on its condition.

Thank You!

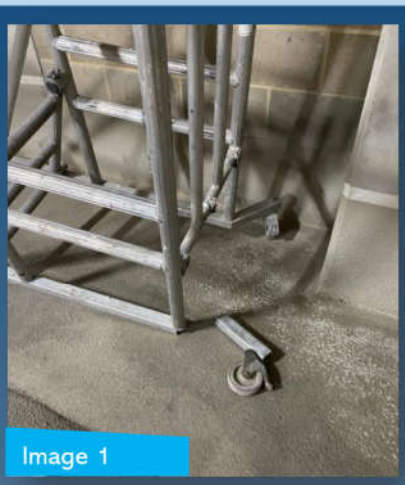
Image 1

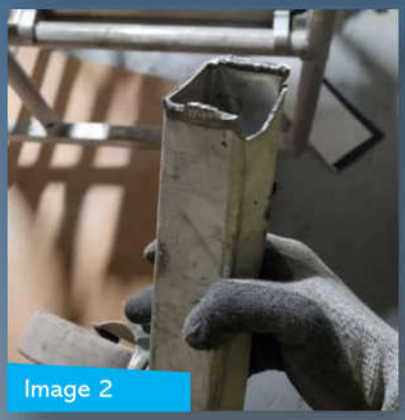
Image 2


Image 3

highways england

INFORMATION

Safety Alert

Duct Bracket Failure

6 August 2021

Background information

- On the 18 July, brackets securing a steel duct to the underside of a bridge, over the A282 trunk road, failed. The duct fell on the trunk road below causing damage to customers' vehicles and minor injury to at least one vehicle occupant. The incident led to the road being closed.
- The duct was installed when the bridge was built in 1992 to carry a future gas main and has remained unused since construction.
- The duct was fixed using a proprietary system consisting of hangers formed from threaded steel bars and couplers, fixed to a track cast into the underside of the deck slab. The duct was secured with a two-piece steel circular clamp bolted on either side.
- Initial investigation of the incident indicates that the installed system had a low level of redundancy and was insufficient to support the duct in the event of a single bracket failure. The brackets failed progressively along the length of the duct, but it has not yet been possible to identify where the initial failure occurred.
- Failure was identified in the pipe clamps at the majority of locations, including 'pull-through' of the clamping bolts. Additionally, a failure was also identified in a coupler connection to one hanger.
- Corrosion to the brackets was identified to all components.

Lessons Learnt

- Inspectors should be aware of the risks associated with similar systems fixed to the underside of structures and record their condition during inspections
- Current standards require that the structural design of new or modified hanger/fixing system include redundancy checks to avoid failure of a single component leading to the failure of the entire system.
- For legacy systems of this type it should not be assumed that they have an adequate factor of safety and redundancy.
- The design or modification of such systems requires approval of the Technical Approval Authority in accordance with CG 300.

If you have any queries about this safety alert information announcement or any other safety announcement then please contact **Fionn.Purcell@highwaysengland.co.uk**

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HEi263

Safety Bulletin

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Incident Response Packs
(NR/L2/OHS/019)

Issued to: **Network Rail line managers, safety professionals and accredited contractors**

Ref: NRB21-08

Date of issue: 05/08/2021

Location: National

Contact: Martin Biggin, Trackworker Safety Specialist, Technical Authority

Overview

Assurance and investigations have found instances where Incident Response Packs (IRPs) have been used rather than Safe Work Packs planned in advance.

The examples did not comply with the company standard NR/L2/OHS/019.

This bulletin is to clarify when Incident Response Planning can be used.

The Incident Response Module in the 019 standard only applies for unforeseeable events which cannot be pre-planned where:

- there is no Planner available, out of normal hours of duty Monday to Friday;
- short timescale faults arise which have to be done over a weekend when no Planners are at work;
- an incident number has been generated by Route/Fault Control; or
- someone is appointed as Rail Incident Officer or pilot for an emergency or failure.

Discussion Points

- Do you always consider the Worksafe procedure if you do not believe you can carry out the work safely?
- When using an Incident Response Pack SSOW how do you double check you have chosen the safest appropriate SSOW?
- When attending a fault of failure what helps you to always start at the top of the hierarchy in NR/L2/OHS/019 when selecting the SSOW?

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Quality Alert

Batching Plant Incident - Stone at AA / Sunk Crane Wheel

In the Aylesbury Area section, while a 60 tonne mobile crane was travelling over a designed "aggregate storage platform" to set up for a lifting operation, the wheels penetrated the base approximately 200 mm, causing severe rutting. The planned lift was aborted in that location and an investigation has commenced.

What we know

- A stone storage platform was built to a Temporary Works (TW) design, the thickness of base required was dependant on California Bearing Ratio tests (CBR tests – also known as the Plate Load tests)
- The platform was subsequently designed to be 360 mm thick with geogrid stone fill
- The crane due to be set up was trafficked across the stone. In doing so it sunk and caused ruts 150 – 200mm deep
- On inspection, the stone in the area was not in line with the design; instead of the 360mm on geogrid specified, in some areas it was significantly less and / or Geogrid was missing
- The quality records indicated that the installation was checked and in compliance with the design
- Investigations so far suggest that where new stone was laid elsewhere in the area, in the specific location where the crane sunk, pre-existing stone placed some time ago as a base for welfare cabins was not replaced with the new designed base.
- This, less substantial, base consisted of 300mm of 6F, and only 150mm of type 1 with geogrid
- In addition, when the work was taken to stone the surrounding area, the finished level needed to be significantly lower that the pre-existing stone being left, so this was trimmed back by around 250mm, meaning less than 200mm of 6F was left in some patches.
- As a result a sizeable soft spot was present in the centre of the stone platform, and it was this that the crane sunk into.

Action taken

- The lift planned for in that location was cancelled and investigation is ongoing to determine what went wrong
- Investigative, invasive surveys are taking place over the stone area which include an as-built survey of the formation and the final top layer to help determine whether the required designed thickness has been achieved elsewhere
- A revised suite of checksheets is being added to the BMS to provide these checks going forward on similar works

What you can do

Please be aware of this and pass it onto anyone it may be relevant to:

- Be aware of the improved lifting platform check sheet revised by the TW Lead
- Quality Check sheets to be in place and signed off by the appropriate engineers from the contractor and EKFB
- Permit to Load and associated periodic inspection records must be reviewed and complete in line with the TW procedure.

EKFB

U&A Alert

Potential CRT non-compliance

Earlier this week we were alerted of a potential U&A non-compliance due to top soil being stripped within 15m of the Canal River Trust (CRT) restricted asset.

The team had begun a further investigation and was in the process of raising the incident on HORACE when CRT subsequently confirmed that our activity location was not an actual CRT asset. This was a very narrow escape and lessons must be learned for all protected areas.

What we know

- On Wednesday 27th July, we were alerted of a potential U&A non-compliance due to top soil being stripped within 15m of the Canal River Trust (CRT) restricted area in the Greatworth to Southam (G2S) section
- While extensive discussions had taken place with CRT about our works and paperwork had been completed, it was revealed that the consent had not yet been granted by the CRT
- The team had begun a further investigation and was in the process of raising the incident on HORACE when CRT subsequently confirmed that our activity location was not an actual CRT asset
- This was a very narrow escape and lessons must be learned for all protected areas, including National Trust and Ancient Woodland

Action taken

- The G2S team is looking at specific signage and the use of demarked cones on site
- The comms team has added specific signage for alert to restricted zones to the signage catalogue for sites to order signs as required on page 23 under 'Information Signs'
- Internal investigation into where communication broke down from STOPPD process, work package plan and task briefing

What you can do

Please be aware of this and pass it onto anyone it may be relevant to:

- When carrying out works, please be aware of the geographical location and use the U&A portal to identify restricted zones and communicate these during task briefings; communication to operatives is key in compliance
- If a third party has been consulted, such as CRT, ensure that the paperwork and permission has been formally received before starting works activity
- Display the appropriate new signage in applicable areas as below.

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U&A Alert

U&A 65 reported possible non-compliance for closing a Public Rights of Way without Advanced Notification

There have been 2 incidents to date where it was assumed that rules were being followed when working near Public Rights of Way (PROW). These led to no schedule 4 temporary interference to highways and therefore no Advance Notification or communications to the community. This will mean the local authorities are not aware of our works and they did not get entered on to Street Manager and therefore One.Network which informs the public of works in their area.

Complaints were made at Councillor/MP level and an incident has been raised as potential non-compliance on HORACE, currently under investigation.

What we know

- Schedule 4 part 2 applications are needed for temporary interference in the highway, road closures and diversions along with an Advance Notification 2 weeks prior to works starting
- As the PROWs were not being closed, the authorities and the public were not aware of the works being carried out by EKFB
- In one scenario we occupied part of the PROW where we should have left a minimum width of 3 metres for equestrian and vulnerable users so this should have had a schedule 4
- In the other scenario, whilst some paths were fenced, crossing with plant is seen as interference with the PROW
- Communities are sensitive to impact of Public Rights of Way
- There was confusion around where we need a schedule 4 if we were not closing or diverting a PROW
- There was also confusion where thought a Schedule 4 was in place when needing to close for emergency security reasons
- Appropriate engagement about the works therefore were not communicated to the authorities or the public
- There was a near miss of plant-people interface with the public using unsafe crossings, especially when dogs were off leads
- We need to ensure we work with the authorities and provide the right communication and signage on site to inform and direct the public of the agreed notifications

Action taken

- To allow crossing we will stop traffic and open gates during working hours where applicable
- Drawings will have text as to how we manage that crossing
- Plant will be held 10 metres back when allowing crossing
- The engagement team will work with traffic team to ensure whether an Advanced Notification or newsletter is required
- A standard A3 information board will be provided on site to inform the public of our activity addressing:
    - What we are doing
    - How long it will take
    - HS2 helpline information
- If the PROW is not on the gazetteer, a manual TM1 form will be sent to authorities instead of Street Manager

What you can do

Please be aware of this and pass it onto anyone it may be relevant to:

- Schedule 4 part 2 (c) states a Schedule 4 is needed when works "break up or interfere with any highway or part of a highway (including any sewer, drain or tunnel in it)"
- Any interference in the highway /PROW needs a Schedule 4 as referenced in point C above such as crossing over some PROWs, partial closure or crossing with plant.
- Closures need an Advance Notification 2 weeks prior to works starting, other interferences will require a newsletter with site signage to keep key stakeholders and the public informed
- If there is an urgent safety issue to ensure people plant segregation, consider securing areas with heras/other fencing as appropriate. Where gated consider pram/vulnerable /equestrian users
- Consider safety out of hours
- A risk assessment needs to be carried out to assess the potential impact on members of the public

Tree Shears and Grapple Saws

FISA and ARB Association are currently producing a new safety guide 608 relating to Tree Shears and Grapple Saws. It has become evident that we need to alert the industry to some potential issues that need to be taken into immediate operational consideration.

Grapple Saws - Chain shot

Chain shot is the high velocity separation and ejection of a piece or pieces of cutting chain from the end of a broken chain in mechanised felling of timber. Chain shot exposes both machine operators and bystanders to a risk of serious injury or death. Chain shot typically occurs near the drive end of the cutting system but can also come from the bar tip area.

- Confirm with Manufacturer if the Grapple Saw requires chain shot protective device/guard to be fitted – as required by BS EN ISO11850 2011 (amended 2016) Machinery for Forestry: General Safety Requirements Section 4.3.2.3. Ensure tested to BS11837-2011 chain shot guarding systems.*Where manufacturer is awaiting testing, please apply chain shot considerations into your risk assessment as explained in Chain shot what is the risk*
- Ensure chain, saw bar & drive sprockets are in good condition and wear is within allowable limits. Ensure that chains are maintained as per manufacturers' recommendations.
- Ensure you use the correct chain lubrication and flow rates.
- Ensure your machine settings are correct. An over-speeding chain or excessive bar force increases your chances of chain shot.
- Your machine must be fitted with a protective screen; the screen must be tested to BS ISO 21876.
- Be aware of chain shot risk zones – do not cut with front or back of saw box pointing towards the operator.

Tree Shears / Grapple Saws – Risk Zones

You should apply and adopt the risk zone recommended by the Original Equipment Manufacturer of your Grapple Saw / Tree Shear in their operational manual.

In all cases it is highly advisable that a Site Specific Risk Assessment is carried out taking into consideration risk zones, particularly in urban settings, and consideration of landing zones and machine stability, before operations commence. Your risk assessment must detail how you will take reasonable steps to undertake the work safely. When planning the operation other key considerations must include the base machine stability and 'load capacity' of both the cutting head and the base machine. It is advisable that all users contact the equipment manufacturers for guidance on the safety of the equipment. You must consider relevant PUWER / LOLER / ACOP regulations.

FISA-AA Tree Shears and Grapple Saws Safety Alert – April 2021 Issue Update (2) Ver 7 *Page 1*

Tree Shears and Grapple Saws

Tree Shears – Grapple Saws – PUWER / LOLER Regulations

The use of grapple saws or tree shears is a lifting operation, as defined by the Lifting Operations and Lifting Equipment Regulations (LOLER) as it involves the lowering of a load. Reg 8(1) of LOLER requires that every lifting operation involving lifting equipment is properly planned by a competent person who is appropriately supervised and carried out in a safe manner.

The plan should address the risks identified by the risk assessment and identify the resources required, the procedures and responsibilities, to ensure that risks are managed, and any lifting operation is carried out safely and that the equipment remains safe for the range of lifting operations for which it might be used.

As such, all lifting operations require a lift plan drawn up by a competent person to be in place (consider access to an Appointed Person as defined in BS7121), irrespective of the lifting equipment and accessories being used to undertake the lift e.g. lorry loader crane, mobile crane, telehandler/loader or excavator. Due to the significant hazards and risks posed by tree felling operations a generic plan may be produced, however the plan will need to be reviewed on a site-by-site basis, following the carrying out of a risk assessment, to ensure that it remains relevant and, where necessary, additional controls are put in place.

PUWER reg 4 requires that the base machine should be assessed by a competent person as to its suitability for the operating attachment and its stability when fitted with the attachment. The base machine should also be fitted with Ops (protective screen) BS ISO 21876, FOPs (falling object protection guard), and ROPs (roll over protection system). The machine should also have visible or audible overload warning (loads over 1 tonne), check valves, be marked with SWL and be subject to LOLER thorough examination (if operator not protected by FOPS/OPS/ROPS or if there is a risk that loads may be lifted over or close to people).

The FISA Plant & Equipment Working Group has released this safety alert in advance of the new FISA 608 Tree Shear & Grapple Saw Safety Guide. The new safety guide will provide an outline of the key safety points associated with this new equipment that is a rapidly growing sector in tree work.

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Making **better** decisions…

Changing **lives**"